GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Special Education Programs
DC Early Intervention Program

DC EIP REFERRAL FORM

CHILD IDENTIFICATION INFORMATION			
Child's Legal Name(Last, First, Middle , (*Optional – nickname*))			Date of Birth
Gender Male ☐ Female ☐ Undetermined ☐	Ethnicity/Race	Insurance Name	Insurance Number
Parent(s)/Legal Guardian			Telephone
Parent(s)/Legal Guardian Address			Ward
Primary Language Spoken by Parent(s)/Legal Guardian ☐ English ☐ Spanish ☐ Other____			
Foster Parent(s) (if applicable)			Telephone
Foster Parent(s) Address (if applicable)			County/Ward
How long has child resided at residence?			Surrogate/Advocate/Guardian *ad Litum?* ☐ YES ☐ NO
If *ad Litum* is yes, Name:			Telephone
Assigned CFSA Caseworker			Telephone

REFERRAL INFORMATION	
Name of Referring Person	Agency/Practice
Phone	Fax
Are you a Qualified Health Professional? ☐ YES ☐ NO Discipline: _____	Has a developmental screening been completed ? ☐ YES ☐ NO Tools Used:_____

Please check and complete one of the following boxes:

☐ A) This child has a current screening/evaluation demonstrating need or is currently receiving services for a diagnosed condition. Describe:_____

☐ B) This child has been diagnosed with a physical or mental condition(s) known to have a high probability of resulting in significant delays in development (even if no delays are apparent at this time): Describe:

_____

☐ C) There are concerns for possible delays in development in the following areas:

_____

Signed: _____ Date of Referral: _____
Referring Person

RETURN REFERRAL TO:
810 First Street, NE, 5th Floor, Washington, DC 20002 Phone: Office (202) 727-3665 ◆ Fax: (202) 724-7230◆
www.osse.dc.gov

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PART C EVALUATION
CONSENT TO RELEASE INFORMATION

It has been explained to me that because of my child's premature birth, birth complications, and/or developmental concerns, my child and family may be eligible for special services designed to assist my child in achieving his or her developmental milestones.

I hereby authorize _____ to release the following information to **the**
(referral source)

DC Early Intervention Program for the purpose of establishing my child's eligibility for early intervention services.

Check all that apply:

☐ Referral Information	☐ Physical Therapy Evaluations	☐ Developmental Screening Results
☐ Admission Summary	☐ Occupational Therapy Evaluations	☐ Hearing Screen/Test Results
☐ Discharge Summary	☐ Speech Therapy Evaluations	☐ Vision Screen/Test Results
☐ Other:_____	☐ Other:_____	☐ Other:_____

Please read and then check all boxes to indicate that you understand your rights before signing. If you have any questions about your rights, please call the DC Early Intervention Program at (202) 727-3665).

☐ I understand that signing this authorization is not a condition of receiving future medical treatment or early intervention services.

☐ I understand that I may revoke (i.e. cancel) this authorization at any time by notifying the DC Early Intervention Program in writing, and that any information shared prior to revoking this authorization will not be affected by a revocation.

☐ I understand that before any specific services for my child are provided, I also have a right to authorize or decline those services

☐ I understand that once released, my information may be disclosed and may no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA), but will not be re-disclosed by the DC Early Intervention Program in accordance with the Family Educational Rights and Privacy Act (FERPA). For more information, see 45 CFR (Code of Federal Regulations) 164.508 for HIPAA and 34 CFR Part 99 for FERPA

☐ I understand that this consent will expire in one (1) year and that a new consent form will need to be completed should I choose to continue with the DC Early Intervention Program.

Signed : _____ Date: _____
(Parent/Legal guardian)

Signed: _____ Date: _____
(Witness)

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INSTRUCTIONS

STEP 1 – ENTER CHILD IDENTIFICATION INFORMATION

ROW 1	ENTER CHILD'S LAST NAME, FIRST NAME, MIDDLE NAME, AND DATE OF BIRTH (DOB)
ROW 2	ENTER CHILD'S GENDER, ETHNICITY, INSURANCE PROVIDER , AND INSURANCE NUMBER (MEMBER ID)
ROW 3	ENTER GUARDIAN'S NAME AND TELEPHONE NUMBER
ROW 4	ENTER GUARDIAN'S ADDRESS AND WARD
ROW 5	CHECK THE CHILD'S PRIMARY LANGUAGE *IF OTHER INDICATE WHAT LANGUAGE*
ROWS 6-10	COMPLETE IF CFSA/COURTS ARE INVOLVED WITH CHILD
	Ad Litum = ATTORNEY ASSIGNED BY THE COURTS

STEP 2 – ENTER REFERRAL INFORMATION

ROW 1	PRINT FIRST AND LAST NAME OF REFERRING PERSON, ENTER REFERRING AGENCY/PRACTICE
ROW 2	ENTER YOUR CONTACT NUMBER AND EXTENSION IF APPLICABLE, AND FAX NUMBER
ROW 3	ARE YOU A QUALIFIED HEALTH PROFESSIONAL IF YES, CHECK YES AND WRITE IN YOUR DISCIPLINE IF NO, CHECK NO
	HAS THE CHILD HAD A DEVELOPMENTAL SCREENING IF YES, CHECK YES AND LIST TOOLS USED AND ATTACH SCREENING DOCUMENT IF NO, CHECK NO
ROW 4	CHECK AND COMPLETE THE APPLICABLE OPTIONS. SIGN YOUR NAME AND DATE THIS REFERRAL WITH TODAY'S DATE.

PAGE 2 – CONSENT TO RELEASE INFORMATION

****THIS PAGE SHOULD BE COMPLETED BY THE PARENT PRIOR TO REFERRAL****

PARENT WILL AUTHORIZE YOU AS THE REFERRAL SOURCE TO RELEASE ANY OF THE CHECKED LISTED DOCUMENTS TO: DC PART C EARLY INTERVENTION PROGRAM (DC EIP). *PLEASE ATTACH ALL CHECKED*.

PARENT WILL CHECK EACH BOX STATING HE/SHE UNDERSTANDS THE STATEMENT OF RIGHTS LISTED.

PARENT/GUARDIAN WILL SIGN AND DATE. WITNESS (REFERRAL SOURCE) WILL SIGN AND DATE.

PARENT SHOULD BE ISSUED A COPY OF THE REFERRAL BY THE REFERRAL SOURCE.

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